APPENDIX B

REQUIRED CLIENT RECORD DOCUMENTATION

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CONSENT FOR RELEASE OF INFORMATION

I hereby give the Virginia Department of Medical Assistance Services (DMAS), Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Community Services Boards (CSB) permission to obtain medical and personal information to assess _____ need for long-term care services.

I understand that these entities will keep this information and take reasonable steps in accordance with law to safeguard the confidentiality of medical and personal records.

I understand that under the Virginia Privacy Protection Act of 1976 I have the right to inspect, correct, or complete this information.

I understand that if I do not provide the information requested, the option of receiving nursing home care in a Medicaid-certified facility or Home and Community-Based Waiver services as a Medicaid recipient may not be given.

I understand that the information requested is necessary to complete an assessment of needs and develop an appropriate plan of long-term care services and, pursuant to a determination of Medicaid eligibility, to authorize Medicaid payment.

These rights and responsibilities have been read by or explained to me and I understand them.

_____
Print name of applicant or applicant's authorized representative

_____ _____
Signature of applicant or applicant's representative Date

_____
Representative's relationship to applicant (parent, guardian, power of attorney)

_____ _____
Witness, if signed by mark Date

_____ _____
Signature of screening authority (registered nurse, social worker, or physician) Date

MEDICAID HIV SERVICES PRE-SCREENING

CLIENT NAME: _____ **MEDICAID NUMBER:** _____

PRE-ADMISSION SCREENING AGENCY: _____ **PROVIDER NUMBER:** _____

ASSESSOR _____ **DATE ASSESSMENT INITIATED** _____

If no Medicaid number now, has the individual formally applied for Medicaid? _____
0 - Yes 1 - No

REFERRAL SOURCE: Circle appropriate response.

0 - self
1 - family/friend
2 - physician
3 - hospital/clinic
4 - home health agency
5 - local social service/ health agency
6 - social security office
7 - community organization
8 - AIDS service organization
9 - Other(_____)

REASON FOR APPLICATION: Circle appropriate response.

0 - Recent deterioration of Medical Status
1 - Other funding sources depleted
2 - Primary caregiver needs relief
3 - Other (_____)

RISK GROUP: Circle appropriate response.

0 - IVDU-Heterosexual
1 - IVDU-Homosexual
2 - Heterosexual (M or F)
3 - Homosexual
4 - Hemophiliac/Blood transfusion
5 - Pediatric
6 - Other (_____)
9 - Unknown

STAGE OF DISEASE AT SCREENING: Circle the appropriate stage

1. Level I Diagnosis -Patient diagnosed as HIV+, is independent, has some symptoms
2 - Level II Early Chronic -Confirmed AIDS, intermittent hospitalizations, may work
3 - Level III Late Chronic -Patient disabled, can't work, needs in-home services
4 - Level IV Terminal - Patient terminally ill and within few weeks of death

IF THE CLIENT:

- Is currently Medicaid eligible or has formally applied

AND

- Is at Level II or greater in the stage of the disease process

THEN CONTINUE ASSESSING THE CLIENTS NEEDS BY:

- Completing the DMAS-95 assessment document
- Completing the Medicaid HIV Services Plan of Care
- Applying the criteria for hospital or nursing facility level of care to the client
- Recommending whether AIDS/ARC Waiver services are an appropriate alternative

AND

- Send the Pre-Admission Screening forms to: Dept. of Medical Assistance Services
  Community Based Care, AIDS Waiver
  600 East Broad Street, Suite 1100
  Richmond, Virginia 23219

ASSESSMENT PROCESS

NAME: Joan Smith | HOME ADDRESS: 333 Cherry Lane, Anywhere, VA 23456 | TELEPHONE NUMBER: 804/555-2345

SUMMARY OF PROVIDERS

RECORD NUMBER	PROVIDER NAME	PROVIDER ADDRESS	TELEPHONE NUMBER	PROVIDER NUMBER	SOURCE	DATES OF ADMISSION	DATES OF DISCHARGE
23234567	CBA Rehabilitation	100 Berry Road	804/555--	Medicare	49Z000	12/13/90	1/25/91
		Anywhere, VA 23456	1234	Medicaid	498888		
	ABC Health Co.	600 E. Cherry Ln.			870000	1/26/91	

BIRTHDATE (MONTH / DAY / YEAR): 08 / 10 / 19

BIRTHPLACE (SPECIFY STATE OR COUNTRY): ☒ USA 0 ☐ OTHER 1 _____

SEX: ☐ MALE 0 ☒ FEMALE 1

MARITAL STATUS (Length of Time): ☐ MARRIED 0 ☐ SEPARATED 2 ☐ SINGLE 4 ☐ WIDOWED 1 ☐ DIVORCED 3 ☐ UNKNOWN 9

RELIGIOUS PREFERENCE
☐ CATHOLIC 0 ☐ OTHER 3 8 _____
☐ JEWISH 1-SECT _____
☒ PROTESTANT 2—SECT _____

RACIAL/ETHNIC BACKGROUND
☐ AMERICAN INDIAN OR ALASKAN NATIVE 0 ☐ BLACK 2 (NOT HISPANIC) ☒ WHITE 4 (NOT HISPANIC)
☐ ASIAN OR PACIFIC ISLANDER 1 ☐ HISPANIC 3 ☐ OTHER 5 _____

EDUCATION
☐ GRADUATE COLLEGE 0 ☐ ELEM. 6/HIGH SCHOOL GRADES COMPLETED 5 _____
☐ UNDERGRADUATE COLLEGE Degree 1 or yrs. 2 _____ ☐ SPECIAL EDUCATION 7
☐ TRADE, TECHNICAL VOCATIONAL 3 ☐ NO SCHOOLING 8
☐ HIGH SCHOOL DIPLOMA 4 ☒ UNKNOWN 9

FAMILY INCOME
☐ $20,000 OR MORE 0 ☐ $3,600 - $4,999 4
☐ $15,000 - $19,999 1 ☐ $2,600 - $3,599 5
☐ $10,000 - $14,999 2 ☐ $2,599 OR LESS 6
☒ $5,000 - $9,999 3 ☐ UNKNOWN 9

USUAL LIVING ARRANGEMENTS

	ALONE 1	SPOUSE 2	OTHER 3,7
☒ HOME/APARTMENT 0		x	Daughter and son-in-law
☐ RENTED ROOM(S) 1			

☐ DOMICILIARY/PERSONAL CARE FACILITY 20
☐ HEALTH CARE FACILITY 3 -TYPE 1,5 _____
☐ OTHER 40 _____

HEALTH CARE COVERAGE
☒ MEDICARE 1 # 890890890B PARTS: ☐ A 2 ☐ B
☒ MEDICAID 1 # 222333444555
☒ OTHER 1 TYPE 1,6 Blue Cross # X223344556
☐ VETERAN 0 ☐ NON-VETERAN 1 ☐ UNKNOWN 9
SOCIAL SECURITY # 444-00-0000

NUMBER OF LIVING CHILDREN 2
SON(S) 1 DAUGHTER(S) 1

EMPLOYMENT STATUS
☐ EMPLOYED 0 ☐ RETIRED 2
☐ PRE-RETIREMENT 1 ☐ PENSION 1
☐ POST-RETIREMENT 2 3 ☐ NO PENSION 2
☐ UNEMPLOYED 10 ☒ NEVER EMPLOYED 30
☐ UNKNOWN 99

USUAL OCCUPATION
☒ HOMEMAKER 10 ☐ NONE 00
☐ OCCUPATION OUTSIDE THE HOME 2 SPECIFY 1,7 _____

NONINSTITUTIONAL LIVING SPACE
☐ AVAILABLE 0 ☐ NOT AVAILABLE 1 ☐ NOT APPLICABLE 2

YES 0	NO 1	
x		ENTRY STAIRS
	x	ELEVATOR OR OTHER CONVEYANCE AVAILABLE
x		TOILET ROOM SAME FLOOR LEVEL AS BEDROOM
x		KITCHEN SAME FLOOR LEVEL AS BEDROOM
		OTHER CONDITION

SOCIAL SUPPORT WILLING AND ABLE TO PROVIDE

YES 0	NO 1		TIMES AVAILABLE
x		ACTIVITIES OF DAILY LIVING/ SUPERVISION	1x
x		HOUSEKEEPING	prn
x		LIVING SPACE	- -
x		MEAL PREPARATION	1x
x		SHOPPING	prn
x		TRANSPORTATION	prn
		OTHER	

DIRECTORY OF HEALTH CARE PROFESSIONALS & OTHERS / UTILIZATION INFORMATION

	NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ASSESSMENT	TYPE OF SERVICE OR LEVEL OF CARE CURRENT 07	TYPE OF SERVICE OR LEVEL OF CARE RECOMMENDED 08	METHOD OF PAYMENT CURRENT 08	METHOD OF PAYMENT EXPECTED 08
REFERRING PHYSICIAN	Dr. Tom Boone	123 Baker Ln. Heath, VA	804/555-2323	1/24/91	acute	personal	Medicare	Medicaid
ATTENDING PHYSICIAN	Dr. Daniel Lee	432 Jackson Ct. Heath, VA	804/555-2344	3/26/91	rehab	care	Medicaid	
ALTERNATE PHYSICIAN					Personal Care	Personal Care	DMAS	DMAS
DENTIST								
PODIATRIST								
PHARMACY								
FUNERAL HOME								
PERSON(S) TO BE NOTIFIED	Jane Smith (dau)		555-2390					
	John Smith (son)		555-2354 (h) 555-2444 (o)					
OTHER								

FORMAT A

MEDICAL STATUS

CHECK BOXES WHICH APPLY
FILL IN SPACES AS INDICATED

NAME OR NUMBER: Joan Smith

	NO IMPAIRMENT 0	IMPAIRMENT (ATTEMPTED) 2 COMPENSATION 1 SPECIFY	NO COMPENSATION 3	COMPLETE LOSS 4	DATE OF CHANGE (IF ANY)
SIGHT		glasses	D		
HEARING	x		D		

SPEECH

- ☐ NO IMPAIRMENT 00
- ☒ IMPAIRMENT 1
  - ☐ STRUCTURE OR MUSCULATURE OF VOCAL TRACT 2
  - TYPE _____
  - ☒ LINGUISTIC SYSTEM 3
- ☐ COMPLETE LOSS 5
- ☐ DOES NOT SPEAK—NO KNOWN IMPAIRMENT 6

PREVIOUS REHABILITATION	COMPLETED 1 ONSET: More Than 6 Months	COMPLETED 1 ONSET: 6 Months Or Less	NOT COMPLETED 2 ONSET: More Than 6 Months	NOT COMPLETED 2 ONSET: 6 Months Or Less
	1	2	1	2
		x		D
				D

DENTITION

- ☐ NO TEETH MISSING OR FEW TEETH MISSING 00
- ☐ SOME OPPOSING TEETH 1
- ☒ NO TEETH OR NO OPPOSING TEETH 2

COMPENSATION TYPE 1	COMPENSATION NONE 2	DATE OF CHANGE
	D	
upper dentures	D	

FRACTURES/DISLOCATIONS ☐ NONE 000

	LOCATION/ TREATMENT	PREVIOUS REHABILITATION PROGRAM YES 1	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED 2	ONSET MORE THAN ONE YEAR 1	ONSET ONE YEAR OR LESS 2
HIP FRACTURE 1(S) 2			D		D
OTHER FRACTURE(S) 3					
DISLOCATION(S) 4					

MISSING LIMBS ☐ NONE 000

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES 1	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED 2	ONSET MORE THAN ONE YEAR 1	ONSET ONE YEAR OR LESS 2
FINGER(S) OR TOE(S) 1			D		
BELOW ELBOW 2			D		
ABOVE ELBOW 3			D		
BELOW KNEE 4			D		
ABOVE KNEE 5			D		

PARALYSIS/PARESIS ☐ NONE 000

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES 1	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED 2	ONSET MORE THAN ONE YEAR 1	ONSET ONE YEAR OR LESS 2
MONOPLEGIA/ PARESIS 1			D		D
HEMIPLEGIA/ PARESIS 2	L side	x	D		D x
PARAPLEGIA/ PARESIS 3			D		D
TRIPLEGIA/ PARESIS 4			D		D
BILATERAL HEMIPLEGIA/PARESIS 5			D		D
QUADRIPLEGIA/ PARESIS 6			D		D

ALLERGIES—SPECIFY ICD-9CM CODE

NKA

DIAGNOSES ICD-9CM CODE | DATE OF ONSET 0 6

DIAGNOSES	ICD-9CM CODE	DATE OF ONSET 0 6
AIDS		11/90

RISK FACTOR MEASUREMENTS/OTHER TESTS

ALCOHOL/SUBSTANCE USE ☐ BY HISTORY - NOT AT PRESENT
☐ NO ☐ YES Type _____ Amount _____ ☐ UNKNOWN

TOBACCO USE ☐ NEVER USED ☐ BY HISTORY-NOT AT PRESENT
☐ CIGARETTES
☐ PIPE
☐ CHEWING
Specify _____
Amount Per Day _____

	RECORD DATE AND READING
HEIGHT	5'2"
WEIGHT IDEAL _____	1/23 114.4
BLOOD PRESSURE	1/25 138/78
BLOOD CHOLESTEROL	12/13 173
BUN	12/13 20
ALBUMINURIA	
BLOOD SUGAR-SPECIFY TEST	12/13 Glucose 149
HEMOGLOBIN OR HEMATOCRIT	12/13 HCT40.8 HGB 14.0
DIG. LEVEL SPECIFY TEST	1/24 1.9
PROTHROMBIN TIME	1/24 18.0
SERUM POTASSIUM	12/13 4.6
CHEST X-RAY 1 2 OTHER	12/13/90

JOINT MOTION SPECIFY JOINTS AFFECTED

	DATE	1/25/91	3/26/91		
WITHIN NORMAL LIMITS 0					
LIMITED MOTION 1 d		RLE	RLE		
INSTABILITY—CORRECTED 2					
INSTABILITY—UNCORRECTED 3 D					
IMMOBILITY 4 D					

MEDICAL HISTORY ICD-9CM CODE

Atrial fibrillation, Rheumatic heart disease, hypertension, DM Type II L Ventricular hypertrophy, UTI, Systemic anticoagulation

FAMILY HISTORY ICD-9CM CODE

Unknown

FUNCTIONING STATUS

MH = MECHANICAL HELP
HH = HUMAN HELP

NAME OR NUMBER: Joan Smith

ACTIVITIES OF DAILY LIVING (ADL)

BATHING

	DATE	1/25	3/26
WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2	D	X	
MH AND HH 3	D		X
IS BATHED 4 OR DOES NOT BATHE 5	D		
DESCRIBE HELP			

DRESSING

WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2	D	X	X
MH AND HH 3	D		
IS DRESSED 4	D		
IS NOT DRESSED 5	D		
DESCRIBE HELP			

TOILETING

WITHOUT HELP 0 DAY & NIGHT			
MH ONLY 1			
HH ONLY 2	D	X	
MH AND HH 3	D		X
DOES NOT USE TOILET ROOM 5	D		
DESCRIBE HELP			

TRANSFERRING

WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2	D	X	
MH AND HH 3	D		X
IS TRANSFERRED 4	D		
IS NOT TRANSFERRED 5	D		
DESCRIBE HELP			

BOWEL FUNCTION

CONTINENT 0		X	
INCONTINENT 1 LESS THAN WEEKLY			X
OSTOMY-SELF CARE 2			
INCONTINENT 3 WEEKLY OR MORE	D		
OSTOMY - NOT SELF CARE 4	D		
TYPE OF OSTOMY OTHER PROBLEM 5			

BLADDER FUNCTION

	DATE	1/25	3/26
CONTINENT 0		X	
INCONTINENT 1 LESS THAN WKLY			X
EXTERNAL DEVICE SELF CARE 2			
INDWELLING CATHETER SELF CARE 3			
OSTOMY SELF CARE 4			
INCONTINENT 5 WEEKLY OR MORE	D		
EXTERNAL DEVICE NOT SELF CARE 6	D		
INDWELLING CATHETER NOT SELF CARE 7	D		
OSTOMY NOT SELF CARE 8	D		
TYPE OF OSTOMY OTHER PROBLEM			

EATING/FEEDING

WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2	D	X	X
MH AND HH 3	D		
SPOON FED 4	D		
SYRINGE OR TUBE FED 5	D		
FED BY IV OR CLYSIS 6	DD		
DESCRIBE HELP			

BEHAVIOR PATTERN

APPROPRIATE 0	I	X	X
WANDERING-PASSIVE LESS THAN WEEKLY 1	I		
WANDERING-PASSIVE WEEKLY OR MORE 2	d		
ABUSIVE, AGGRESSIVE, DISRUPTIVE — LESS THAN WEEKLY 3	D		
ABUSIVE, AGGRESSIVE, DISRUPTIVE — WEEKLY OR MORE 4	DD		
COMATOSE 5			
TYPE OF INAPPROPRIATE BEHAVIOR			

ORIENTATION

ORIENTED 0	I		
DISORIENTED - SOME SPHERES SOME TIME 1	d	X	X
DISORIENTED - SOME SPHERES ALL TIME 2	d		
DISORIENTED - ALL SPHERES SOME TIME 3	D		
DISORIENTED - ALL SPHERES ALL TIME 4	D		
COMATOSE 5			
SPHERES AFFECTED			

MOBILITY LEVEL

	DATE	1/25	3/26
GOES OUTSIDE WITHOUT HELP 0			
GOES OUTSIDE MH ONLY 1	d		
GOES OUTSIDE HH ONLY 2	D	X	X
GOES OUTSIDE MH AND HH 3	D		
CONFINED MOVES ABOUT 4	D		
CONFINED—DOES NOT MOVE ABOUT 5	D		
DESCRIBE HELP			

WALKING

WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2			
MH AND HH 3		X	X
DOES NOT WALK 4			
DESCRIBE HELP			

WHEELING

DOES NOT WHEEL-MOVES ABOUT 0			
WITHOUT HELP 1			
MH ONLY 2			
HH ONLY 3		X	X
MH AND HH 4			
IS WHEELED 5			
IS NOT WHEELED 6			
DESCRIBE HELP			

STAIRCLIMBING

WITHOUT HELP 0			
MH ONLY 1			
HH ONLY 2			
MH AND HH 3			
DOES NOT CLIMB 4		X	X
DESCRIBE HELP			

COMMUNICATION OF NEEDS

VERBALLY-ENGLISH 0		X	X
VERBALLY — OTHER LANGUAGE 1			
NONVERBALLY 2			
DOES NOT COMMUNICATE 3			
OTHER LANGUAGE NONVERBAL COMMUNICATION			

SERVICES CURRENTLY RECEIVED

FILL IN SPACES AS INDICATED

NAME OR NUMBER: Joan Smith

THERAPIES

	DATE 1/25/91	SPECIFY FREQUENCY 3/26/91		
INHALATION				
OCCUPATIONAL	2x/dy			
PHYSICAL	2x/dy			
SPEECH	1x/dy			
REALITY/ REMOTIVATION				
SOCIAL SERVICE	prn	prn		
OTHER				

OTHER SERVICES/SOCIAL CONTACTS

RECREATION/ ACTIVITIES	4x/wk			
RELIGIOUS SERVICES				
VISITORS				
OTHER				

NUTRITION

DIET—SPECIFY	soft	soft		
FOOD/FLUID INTAKE-NO PROB. (✓)				
PROBLEM— SPECIFY				
SUPPLEMENTAL NOURISHMENTS				
DINING LOCATION				

SPECIAL NURSING PROCEDURES

SPECIFY SITES WHERE APPLICABLE TYPE AND FREQUENCY OF TREATMENT

DECUBITUS CARE SITE(S)				
DRESSING(S) SITE(S)				
EYE CARE— SPECIFY				
OXYGEN Rx— TYPE				
RESTORATIVE NURSING: BOWEL[1] /BLADDER[2] TRAINING[3] ROM EXERCISES SITES[1,4] OTHER				
RESTRAINTS-SITES OF APPLICATION				
TEACHING: OSTOMY CARE-TYPE / SELF INJECTION / OTHER				
OTHER SPECIAL NURSING				

PROFESSIONAL VISITS

SPECIFY FREQUENCY OF VISITS

ATTENDING MD/DO	daily / 1 x mon.
OTHER MD/DO	
AUDIOLOGIST	
DENTIST	
OPHTHALMOLOGIST/ OPTOMETRIST	
PODIATRIST	
HOME HEALTH	
OTHER	

MEDICATIONS

SPECIFY EACH MEDICATION BY CATEGORY. INCLUDE DOSE, ROUTE OF ADMINISTRATION, FREQUENCY, AND TIME OF LAST DOSE AT DISCHARGE. CHECK IF ADMINISTERED UNDER CORRESPONDING DATE.

DATE: 1/25 | 3/26

ANALGESICS/ NARCOTICS	Tylenol Tabs 04 hrs prn	x	x
ANTACIDS			
ANTIBIOTICS/ ANTI-INFECTIVES	Cipro 500 mg Bid		x
ANTICOAGULANTS			
ANTICONVULSIVES			
ANTIHYPER-TENSIVES			
BOWEL REGULATORS	Therevac qod		x
CARDIAC REGULATORS			
DIURETICS/ ELECTROLYTES			
INSULIN HYPOGLYCEMICS			
SEDATIVES/ BARBITURATES			
TRANQUILIZERS/ ANTIDEPRES-SANTS			
VASODILATORS			
VITAMINS/IRON			
OTHER	AZT 1 tab q 6 hrs	x	x

MEDICATION ADMINISTRATION

NO MEDICATIONS 0				
SELF ADM. MONITORED LESS THAN WEEKLY 1				
BY LAY PERSONS MONITORED LESS THAN WEEKLY 2		x		
BY LICENSED/PROF. NURSE AND/OR MONITORED WEEKLY OR MORE 3	x			
BY PROFESSIONAL NURSE 4				

TRANSLATION TO SERVICE NEEDS

1 RECORD THE DATE OF ASSESSMENT
2 MATCH THE ASSESSED STATUS RECORDED AS d, D, OR DD IN THE COMPLETED ASSESSMENT WITH THE SAME ITEMS IN THE ASSESSED STATUS COLUMN BELOW. CHECK THE SERVICE(S) NEXT TO EACH MATCHED ITEM UNDER THE DATE OF ASSESSMENT
3 MATCH THE ASSESSED STATUS FOR BEHAVIOR PATTERN WITH THAT OF ORIENTATION AND CHECK THE CORRESPONDING SERVICE AS NEEDED IF THE ASSESSED STATUS IS "1" FOR BEHAVIOR AND ORIENTATION, NO SERVICE IS CHECKED AS NEEDED

ASSESSED STATUS	DATE	SERVICE NEEDS 1	✓ OR SPECIFY IF CHANGE OCCURS RECORD DATE AND CHANGE: SOCIAL SUPPORT 1	SERVICE PROVIDER	AT REASSESSMENT DATE AND ✓ IF SERVICE RECEIVED 1
NON-INSTITUTIONAL LIVING SPACE D Not Available		HOMEFINDING SERVICE			
SIGHT D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION		OPHTHALMOLOGY/OPTOMETRY			
HEARING D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION		AUDIOLOGY			
SPEECH D IMPAIRMENT SIX MONTHS AGO OR LESS — THERAPY NOT COMPLETED		SPEECH THERAPY			
DENTITION D SOME OR NO OPPOSING TEETH — NO COMPENSATION		DENTAL SERVICE			
FRACTURED HIP(S) DD PARALYSIS/PARESIS DD ONE YEAR AGO OR LESS AND REHABILITATION NOT COMPLETED		PHYSICAL THERAPY			
MISSING LIMBS D REHABILITATION NOT COMPLETED					
JOINT MOTION INSTABILITY UNCORRECTED OR IMMOBILITY D LIMITED MOTION d					
EATING/FEEDING DD FED BY I.V. OR CLYSIS		PROFESSIONAL NURSING			
MEDICATION ADMINISTRATION SOME OR ALL BY PROFESSIONAL NURSE D BY LICENSED OR PROFESSIONAL NURSE d		LICENSED OR PROFESSIONAL NURSING			
ACTIVITIES OF DAILY LIVING ADL: BATHING, DRESSING, TOILETING, TRANSFERRING, BOWEL FUNCTION, BLADDER FUNCTION, EATING/FEEDING D FOR 5, 6, OR 7 ADL D FOR 2, 3, 4, 5, 6, OR 7 ADL		MEAL PREPARATION			
		HOUSEKEEPING			
		ADL OR SUPERVISION BY LAY PERSONS OR AIDES			
BEHAVIOR PATTERN / ORIENTATION 1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND d-DISORIENTED SOME SPHERES					
d-WANDERING/PASSIVE WEEKLY OR MORE AND 1-ORIENTED					
1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND D-DISORIENTED ALL SPHERES		EMOTIONAL AND SOCIAL ASSESSMENT SERVICES			
d-WANDERING/PASSIVE WEEKLY OR MORE AND d,D-DISORIENTED SOME OR ALL SPHERES					
D-ABUSIVE/AGGRESSIVE DISRUPTIVE LESS THAN WEEKLY AND 1, d, OR D DISORIENTED					
DD-ABUSIVE/AGGRESSIVE/DISRUPTIVE WEEKLY OR MORE AND 1, d, OR D DISORIENTED		EMOTIONAL AND SOCIAL TREATMENT SERVICES			
MOBILITY LEVEL d, D GOES OUTSIDE WITH HELP OR DOES NOT GO OUTSIDE		SHOPPING			
OTHER SERVICE NEEDS					

NAME OR NUMBER: Joan Smith

ADDITIONAL INFORMATION/PLAN

Patient needs assistance with ADLs, meal preparation, laundry and shopping.

Patient's daughter and son-in-law live w/her and her husband. However, both must work.

Patient's husband is non-ambulatory and has cognitive defects.

Patient should not be left unattended because she has anomia, apraxia and aphasia. She is unable to comprehend what is said to her. It is difficult for her to express herself. Her processing is severely impaired. Her yes/no responses are not reliable.

Until the last few days, patient did not appear to be impulsive. She is now beginning to be impulsive.

PREFERENCES ☐ NONE0		
FOOD 1	ACTIVITIES, HOBBIES, INTERESTS 2	OTHER 3

REASON FOR REFERRAL/DISCHARGE

IF DECEASED 1 CAUSE OF DEATH — HCDA CODE DATE

PHYSICIAN'S SIGNATURE

PHYSICIAN'S ORDERS FOR CARE

NAME OR NUMBER

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED ( ) INTERMEDIATE) NURSING CARE ( ) OTHER PROFESSIONAL) SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) MEDICAID REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______________ AT LEAST EVERY ______ MONTHS

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED ( ) INTERMEDIATE) NURSING CARE ( ) OTHER PROFESSIONAL) SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) MEDICAID REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______________ AT LEAST EVERY ______ MONTHS

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED ( ) INTERMEDIATE) NURSING CARE ( ) OTHER PROFESSIONAL) SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) MEDICAID REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______________ AT LEAST EVERY ______ MONTHS

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED ( ) INTERMEDIATE) NURSING CARE ( ) OTHER PROFESSIONAL) SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS **OR** ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE ( ) MEDICAID REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______________ AT LEAST EVERY ______ MONTHS

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

ADDITIONAL COMMENTS/JUSTIFICATIONS/RECOMMENDATIONS/DECISIONS

SIGNATURE	SIGNATURE	SIGNATURE	SIGNATURE
AFFILIATION	AFFILIATION	AFFILIATION	AFFILIATION

MI/MR SUPPLEMENTAL ASSESSMENT

A. This section is to be completed by the NH Pre-Admission Screening Committee.

Name _____ **Date of Birth** _____
Social Security Number _____ **Medicaid Number** _____
Local CSB Responsible _____ **Date NHPAS Request Received:** _____

1. **DOES THE INDIVIDUAL HAVE A CURRENT DIAGNOSIS OF MI?** ___ yes ___ no **MR?** ___ yes ___no

   Diagnosis: _____

2. **DOES THE INDIVIDUAL HAVE A RECENT (WITHIN 2 YEARS) HISTORY OF MI?** _____

   DOES THE INDIVIDUAL HAVE A HISTORY OF MR? _____ Describe briefly and list date(s) of onset:

   _____

3. **HAS THE INDIVIDUAL BEEN REFERRED BY AN AGENCY SERVING PERSONS WITH MENTAL RETARDATION OR A DEVELOPMENTAL DISABILITY?** ___ yes ___ no
   If yes, specify agency, location, type of service provided, contact person, and phone #: _____

   _____

4. **LIST ANY PRESCRIBED MAJOR TRANQUILIZER OR PSYCHOACTIVE DRUG BELOW:**

Medication	Dosage	Frequency	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____

   Is there a diagnosed neurological disorder or medical justification for the prescription? _____

5. **DOES THE INDIVIDUAL PRESENT EVIDENCE OF MENTAL ILLNESS OR MENTAL RETARDATION?**
   Please check any of the following which the individual is currently exhibiting:

___ is combative	___ sets fires	___ talks about his/her worthlessness
___ has an appetite disturbance	___ exhibits bizarre behavior	___ is unable to understand simple commands
___ is withdrawn/depressed	___ bangs head	___ experiences difficulty learning new skills
___ has epilepsy	___ uses self-stimulatory behavior	___ is destructive to self/property
___ has a sleep disturbance	___ exhibits seriously impaired judgment	___ demonstrates severe maladaptive behavior(s)
___ hallucinates	___ displays inappropriate social behavior	___ has face or body twitches or jerks
___ has delusions	___ has suicidal thoughts, ideations, & gestures	___ has specialized training needs
___ is disoriented	___ cannot communicate basic needs	___ other _____

6. **RECOMMENDATION:**

   ___ **REFER TO** _____ **(CSB) FOR LEVEL II ASSESSMENT FOR MI OR MR.**

   Screening Placement Recommendation: ___ Nursing Home ___ Community-Based Care
   Other _____ Date package sent: _____

   ___ **NO REFERRAL FOR LEVEL II ASSESSMENT BECAUSE INDIVIDUAL:**
   - ___ Does not have known or suspected diagnosis of MI or MR.
   - ___ Has a diagnosis of dementia (includes Alzheimer's disease).
   - ___ Has a severe or terminal illness as a primary diagnosis.
   - ___ Requires convalescent care.
   - ___ Is of advanced years and has declined assessment for active treatment needs.

_____ Signature | _____ Title | _____ Name of Screening Committee

_____ Date | _____ Telephone Number | _____ Mailing Address

MEDICAID HIV WAIVER SERVICES PLAN OF CARE

CLIENT: _____ **MEDICAID NUMBER:** _____

DATE OF ASSESSMENT _____

I. PRIMARY CAREGIVER SUPPORT

	Name	Address	Work Phone	Home Phone
PRIMARY:				
OTHERS:				

RELATIONSHIP OF PRIMARY CAREGIVER:
(Circle the appropriate response)

0 - no caregiver
1 - parent
2 - other relative
3 - spouse
4 - partner/lover
5 - friend
6 - Other (_____)

LIVING SITUATION OF PRIMARY CAREGIVER:
(Circle the appropriate response)

0 - no caregiver
1 - with client
2 - separate residence but close in proximity
3 - separate residence, over an hour away

II. SERVICE NEEDS AND SUPPORT SYSTEM:

A. SERVICES INFORMAL SUPPORTS ARE WILLING AND ABLE TO PROVIDE

Needs	Check Those That Apply	Support Available (Use Codes Provided Below)	Frequency (Use Codes Provided)
Activities of Daily Living			
Housekeeping			
Living space			
Meals			
Shopping/Laundry			
Transportation			
Supervision			
Medicine/Medical Needs			
Financial			
Other: _____			
_____			

SUPPORT:

0 - no caregiver
1 - fully capable and willing
2 - able but limited by other reponsibilities
3 - able but limited by attitudes
4 - client does not want help
5 - client does not need this help
9 - Unknown

FREQUENCY:

0 - several times daily
1 - daily
2 - 4-6 times a week
3 - 2-3 times a week
4 - once a week or less

COMMENTS: _____

_____

B. SERVICES PROVIDED BY NON-MEDICAID FORMAL SUPPORT SYSTEM

Type	Those Currently Received	Frequency (Use Codes)	Date Care Started	Provider Name
Health Education				
Support Groups				
Buddies/Companions				
Counseling/Therapy				
Drug Abuse Treatment				
Dental				
Housing				
Home Delivered Meals				
Entitlement/Benefits				
Legal Services				
Child Care				
Foster Care				
Other: (_____)				

COMMENTS: _____

C. MEDICAID SERVICES (NOT COVERED UNDER THE WAIVER)

Type	Those Currently Received	Frequency (Use Codes)	Date Care Started	Provider Name/Type Of Service
Home Health				
Rehabilitation				
Medications				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Transportation				
Hospice				
EPSDT (child health)				
Laboratory Services				
Other: (_____)				

COMMENTS: _____

FREQUENCY:
0 - several times daily
1 - daily
2 - 4-6 times a week
3 - 2-3 times a week
4 - once a week or less
9 - Unknown

D. MEDICAID HIV WAIVER SERVICES

1. **CASE MANAGEMENT:** Recommended Frequency of Contact _____

2. **SKILLED NURSING CARE:** LPN _____ Hours per Day/Week RN _____ Hours per Day/Week
   Nursing Activities Required: _____
   Hours during which Nursing Care is Needed: _____

3. **NUTRITIONAL SUPPLEMENTS:** ____ Sole Nutritional Source ___ Primary Nutritional Source
   Type of Supplement Required: _____
   Amount of Supplement Required: _____

4. **RESPITE CARE:** Routine _____ Hours per Day/Week Episodic _____ Hours per Day/Week
Reason Respite Care Would Be Requested: _____

_____

Caregiver For Whom Respite Care Would Be Intended: _____
Care Must Be Provided By LPN: ___No ___Yes Reason: _____

5. **PERSONAL CARE: SERVICES ARE NEEDED _____ DAYS PER WEEK, REQUESTED _____ HOURS/DAY**

SERVICE NEEDS	PROVIDED BY: FAMILY/ OTHER	PROVIDED BY: PROVIDER AGENCY	SERVICE NEEDS	PROVIDED BY: FAMILY/ OTHER	PROVIDED BY: PROVIDER AGENCY
ADL'S	_____	_____	LAUNDRY	_____	_____
HOUSEKEEPING	_____	_____	TRANSPORTATION	_____	N/A
MEAL PREPARATION	_____	_____	SUPERVISION	_____	_____
SHOPPING	_____	_____	SPECIAL MEDICAL NEED	_____	N/A

COMMENTS: _____

_____

III. RECOMMENDATION

_____ **HOME CARE IS RECOMMENDED** - _____ (name of client) meets the criteria for Home and Community Based Care AIDS/ARC Waiver Services:

- He/She requires the hospital or nursing facility level of care
- He/She is experiencing symptoms that meet the Center for Disease Control's definition of ARC or AIDS.
- Home Care is appropriate to adequately meet the client's needs
- Home Care is necessary to enable the individual to remain in the community; other resources have been utilized where possible.

_____ **HOME CARE IS NOT RECOMMENDED**

___ An Appropriate Plan of Care could not be developed. Reason _____

_____

___ Family/Caregiver decided Home Care was not a viable option.
___ No provider agency is available.
___ Other_____

IV. FREEDOM OF CHOICE

I understand that the Recommendation of the Screening Committee must be authorized by the Department of Medical Assistance Services before services can be approved. I have been informed of the Medicaid-funded AIDS Waiver options recommended and have chosen:

	PROVIDERS CHOSEN
_____ Case Management	_____
_____ Personal Care	_____
_____ Respite Care	_____
_____ Private Duty Nursing	_____

_____ _____
Client Date Physician's signature Date

_____ _____
Pre-Admission Screening Staff Date Pre-Admission Screening Staff Date

_____ _____
Pre-Admission Screening Staff Date Pre-Admission Screening Staff Date

MEDICAID HIV SERVICES AUTHORIZATION

PRE-ADMISSION SCREENING AGENCY: _____ **PROVIDER NUMBER:** _____

CLIENT NAME: _____ **MEDICAID NUMBER:** _____

DATE SCREENING PACKAGE RECEIVED _____ **DATE OF TELEPHONE REQUEST** _____ **(if applicable)**

SERVICES AUTHORIZED:

WAIVER SERVICE	ESTIMATED # UNITS/MONTH	X RATE/UNIT	= ESTIMATED COST/MONTH
1. CASE MANAGEMENT	_____	$ _____	$ _____
2. PERSONAL CARE	_____	$ _____	$ _____
3. SKILLED NURSING	_____	$ _____	$ _____
4. RESPITE CARE	_____	$ _____	$ _____
5. NUTRITIONAL SUPPLEMENTS	_____	$ _____	$ _____
TOTAL ESTIMATED MONTHLY COST OF WAIVER SERVICES			$ _____

IS EQUAL TO/LESS THAN ESTIMATED MONTHLY COST OF HOSPITAL CARE $ 1,529.00

If the cost of current waiver services is not equal to or less than the cost of hospital care, indicate whether these costs are expected to decrease within the individual's first three months of receipt of waiver services. If waiver services can be shown to be cost effective due to this decrease, waiver services can be temporarily authorized. Show the expected utilization beside the current figures above. DMAS will review services at the end of three months to determine continued authorization.

_____

_____

_____

____ **THIS INDIVIDUAL MEETS THE CRITERIA FOR WAIVER SERVICES AND SERVICES RECOMMENDED BY THE NURSING HOME PRE-ADMISSION SCREENING COMMITTEE ARE APPROVED.**

____ **THIS INDIVIDUAL MEETS THE CRITERIA FOR WAIVER SERVICES AND SERVICES RECOMMENDED BY THE NURSING HOME PRE-ADMISSION SCREENING COMMITTEE ARE AMENDED AS SHOWN ABOVE.**

____ **THIS INDIVIDUAL DOES NOT MEET THE CRITERIA FOR WAIVER SERVICES AND SERVICES RECOMMENDED BY THE NURSING HOME PRE-ADMISSION SCREENING COMMITTEE ARE DENIED.**

_____

_____

_____

_____ _____

DMAS AUTHORIZING AGENT SIGNATURE

EFFECTIVE DATE OF THIS AUTHORIZATION
(Indicate if authorization given by phone)

NURSING HOME PRE-ADMISSION SCREENING AUTHORIZATION

Please provide the appropriate answer by either filling in the space or putting the correct number in the box provided.

Name: _____ Social Security Number: _____

Is Currently Medicaid Eligible? _____ Medicaid Number: _____

- If no Medicaid number now, is it anticipated that the individual will be financially Medicaid eligible within 180 days of nursing home? Yes = 2 No = 3 ___
- Has individual formally applied for Medicaid? Yes = 1 No = 0 ___

Dept. of Social Services _____
(Eligibility Responsibility) (Services Responsibility)

NURSING HOME APPLICATION ___
Has the Individual made formal application to a nursing home? ___
1 = Yes _____
0 = No (name of nursing home)
2 = Plans to apply
3 = Is currently a nursing home resident

MEDICAID AUTHORIZATION ___
1 = Nursing Home/Skilled ___
2 = Nursing Home/Intermediate
3 = Personal Care/Skilled
4 = Personal Care/Intermediate
5 = Adult Day Health Care (ADHC)
6 = ADHC + Personal Care
7 = Respite Care
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = None

COMMUNITY-BASED CARE REFUSED ___
This section refers only to those individuals who were offered Community-Based Care and refused. ___
1 = Patient/Family not interested
2 = Could not afford patient pay
3 = Other: _____
8 = Not Applicable

COMMUNITY-BASED CARE NOT OFFERED ___
This section is to be completed when Community Based Care is not offered. ___
1 = Did not meet level of care criteria
2 = Appropriate Plan of Care could not be developed
3 = Plan of Care not cost effective
4 = No provider agency available
8 = Not Applicable

LEVEL II ASSESSMENT DETERMINATION ___ ___
0 = Not referred for Level II assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses nursing home

LENGTH OF STAY (If approved for Nursing Home) ___ ___
1 = Temporary (expected to return home in less than 3 months)
2 = Temporary (expected to return home in less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

SCREENING IDENTIFICATION

- Name of hospital and provider number:
  _____
  _____
  _____
- Name of health department and provider number:
  _____
  _____
  _____
- Social Service City County Code: _____ ___
- Name of Community Services Board and ID number:
  _____
  _____
  _____
- Did the individual expire after the Screening decision but before services were received? ___
  1 = Yes 0 = No ___

SCREENING CERTIFICATION

This authorization, and Community-Based Care Plan of Care, if Community-Based Care services are authorized, is appropriate to adequately meet the recipient's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ R.N., Date _____

_____ S.W., Date _____

_____ M.D., Date _____

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

PATIENT INFORMATION

_____ (Name of Provider)

_____ (Address)

Name _____ Sex _____ Birth Date _____

Home Address _____ Medicaid ID # _____

(For Use By Provider)

I. **PATIENT STATUS:** (Complete Appropriate Blocks)
Report of any admission, discharge, and/or change of patient status.
A. Patient admitted to this facility/service / /
B. Patient discharged or expired on / /
☐ Home ☐ Hospital ☐ Other Institution ☐ Expired
C. Patient level of care has changed from _____ to _____
D. Request eligibility ☐ Determination or ☐ Confirmation

II. **REQUEST NEW MAP-122 FOR FOLLOWING REASON, CHECK ONE:**
A. MAP Audit indicated:
☐ 1. Patient Personal or Maintenance Allowance not indicated on present MAP-122
☐ 2. Patient's income has changed. Latest _____ (Source) Check amount is _____
☐ 3. Patient pay effective date not shown on Map-122 dated _____.
B. Other (Explain)

III. **INFORMATION:** (To Be Completed by Nursing Home Only)
The Personal Fund Account is Within $100.00 of the Medicaid allowed limits.
PFA is $_____ as of _____ (Date).

Name _____

Title _____ Date _____

REMARKS:

(For Use by Social Services)

IV. A. **ELIGIBILITY INFORMATION** (Check one)
1. ☐ Has been found eligible for Medical Assistance effective _____ (Date)
2. ☐ Does not meet the eligibility requirements for Medical Assistance
3. ☐ Is currently a recipient of Medical Assistance

B. **FINANCIAL INFORMATION**
1. Recipient/patient has the following resources from which payment responsibility is determined: (Show full benefit from all sources.)
a. $_____ Social Security
b. $_____ VA
c. $_____ Retirement
d. $_____ Other Source
Total $_____
2. $_____ a month is allocated for the patient's personal or maintenance needs.
3. $_____ a month is allocated for the need of dependents at home, if appropriate.
4. $_____ Other _____
5. $_____ a month is to be paid toward the cost of care beginning

NOTE: Income is to be applied to the cost of care in the month in which it is received, e.g., SSA checks received in January are applicable to the cost of care for January.

6. ☐ Has no responsibility to pay toward cost of care.

_____ Social Services Dept.

Name _____

Title _____ Date _____

NOTE: INSTRUCTIONS ON REVERSE SIDE

DMAS-122 R11/84

INSTRUCTIONS FOR COMPLETION
DMAS-122

PURPOSE OF FORM—For a local social services department and a nursing home or personal care provider to exchange information with respect to: (1) responsibility of an eligible patient to make payment toward the cost of care, (2) change in the level of care, (3) admission or discharge of a patient to an institution or personal care services, or death of patient, (4) or other information known to the provider that might involve a change in eligibility or patient pay responsibility.

USE OF FORM—To be prepared initially by either the provider or the local social services department for each nursing home or personal care patient at the time of eligibility determination or entry into the nursing home or personal care services program, to give the provider appropriate financial information. A new form is to be prepared by the local social services department at the time of each redetermination of eligibility and whenever there is any change in the patient's circumstances that results in a change in the amount of income to be paid toward the cost of care.

The form shall be prepared by the provider to request a Medicaid number, or eligibility determination or confirmation or to notify the local social services department of changes in the patient's circumstances.

NUMBER OF COPIES—Prepare in duplicate for nursing home patients and triplicate for personal care patients.

DISPOSITION OF COPIES—Local social services departments are to send the original to the provider and file the copy in the eligibility case folder. For personal care patients, a copy is sent to the Community-Based Care Section, Virginia Medical Assistance Program. When initiated by the provider, the original is to be sent to the local social services department and the copy filed in the patient's medical records. Personal care providers should send a copy to the Community-Based Care Section also. Forms are to be retained for a period of three years following the current fiscal year if a federal audit has been made within that period and no audit questions have been raised. If such an audit has not been made within that time, the form must be retained until an audit has been made or until the end of five years following the current fiscal year, whichever is earlier. In all cases, if audit questions have been raised, the form must be retained until questions are resolved.

DETAILED INSTRUCTIONS FOR COMPLETING THE FORM—The local social services department or provider, whichever initiates the form, is to complete the heading.

Sections I, II, and III are to be used by the provider to provide information or make specific requests of a local social services department.

Section IV is to be used by the local social services department to provide information concerning a patient's financial responsibility.

In Section IV-A, check the appropriate line 1, 2, or 3 for each applicant/recipient.

Section IV-B is to be completed for each eligible patient as follows: (1) Section IV B.1, enter the amount of income and its source in the space provided; (2) Section IV B.2, enter the income level established for maintenance or personal needs allowance; (3) Section IV B.3, enter the amount of the patient's income that is allocated to dependents at home, if appropriate; (4) Section IV B.4, enter the amount of the patient's income that is allocated to other expenses (such as uncovered medical expenses) and indicate the purpose of the deduction; (5) Section IV B.5, enter the amount to be paid on the cost of care and the date this amount becomes effective; and (6) Section IV B.6, check this block if patient has no responsibility to make a payment toward his cost of care.

The patient pay must be applied to the cost of care each month before Medicaid responsibility begins. The provider must apply the full patient pay or that which covers charges on the first half of split billings.

Income is to be applied to the cost of care in the month in which it is received, i.e., Social Security Administration checks received on January 3 are applicable to the cost of care for January.